Attachment 13-A

OFFICE OF PUBLIC INSTRUCTION
FMLA LEAVE REQUEST FORM

Employee Name_____

Social Security Number_____

Date & Time of Notification_____

Name of Person Taking Information_____

Reason for Absence **Dates Requested**_____

____Annual leave _____Compensatory Time _____FMLA

____Sick leave

Person taking leave for:

___	Self	___	Parent	___	Other family member
___	Spouse	___	Child (Name _____)		

FMLA Qualifying Conditions

___ For birth or placement of a child for adoption or foster care (mother or father)
___ To care for an immediate family member (spouse, child or parent) with a serious health condition
___ To take medical leave when the employee is unable to work because of a serious health condition

A "serious health condition" means an illness, injury, impairment, or physical or mental condition that involves:

* any period of incapacity or treatment connected with inpatient care (i.e., an overnight stay) in a hospital, hospice, or residential medical care facility;

* any period of incapacity requiring absence of more than three calendar days from work, school or other regular daily activities that also involves continuing treatment (or under the supervision of) a health care provider;

* continuing treatment by (or under the supervision of) a health care provider for a chronic or long-term health condition that is so serious that, if not treated, would likely result in a period of incapacity of more than three calendar days, and for parental care.

Supervisor/Employee Information

You may want to consider notifying your supervisor or asking your employee the following information when the leave is requested, for example:

Do you have work assignments that are pending that need to be completed by someone else during your absence?

____ Yes ____ No

Are there meetings that need to be canceled and/or other people notified of your absence?
____ Yes ____ No

_____

Who will be responsible for covering during your absence?

_____

Supervisor Information

Has the medical leave request exceeded three (3) working days? ____Yes ____No

Has the leave exceeded five (5) working days? ____Yes ____No (Call the personnel office to determine medical certification requirements).

What type of leave is being requested by employee for an FMLA absence?
_____sick ____annual ____comp time
_____direct grant of sick leave _____leave without pay

_____ _____
Employee Signature Date

_____ _____
Supervisor Signature Date

(Attach form to the time sheet that is completed at the end of the pay period)